## Filing at a Glance

| | |
|---|---|
| Company: | Tufts Insurance Company |
| Product Name: | DC Student Health PPO - Rate Filing |
| State: | District of Columbia |
| TOI: | H04 Health - Blanket Accident /Sickness |
| Sub-TOI: | H04.001 Student |
| Filing Type: | Rate |
| Date Submitted: | 12/27/2013 |
| SERFF Tr Num: | THPC-129352109 |
| SERFF Status: | Assigned |
| State Tr Num: | |
| State Status: | |
| Co Tr Num: | 2013-DC-010 |
| Implementation Date Requested: | 02/01/2014 |
| Author(s): | Paul Hatch, Amanda Toth, Kathy Cotton, Libby Hanrahan, Kristyn McCandless |
| Reviewer(s): | Darniece Shirley (primary), Alula Selassie, Donghan Xu |
| Disposition Date: | |
| Disposition Status: | |
| Implementation Date: | |

State Filing Description:

**State:** *District of Columbia* **Filing Company:** *Tufts Insurance Company*
**TOI/Sub-TOI:** *H04 Health - Blanket Accident /Sickness/H04.001 Student*
**Product Name:** *DC Student Health PPO - Rate Filing*
**Project Name/Number:** */2013-DC-010*

## General Information

Project Name:
Project Number: 2013-DC-010
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Blanket
Filing Status Changed: 01/02/2014
State Status Changed:
Created By: Paul Hatch
Corresponding Filing Tracking Number: 2013-DC-010

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Overall Rate Impact:
Deemer Date:
Submitted By: Paul Hatch

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Enclosed is the initial rate filing for a new Student Health Insurance PPO product to be underwritten by Tufts Insurance Company (TIC). TIC is a Massachusetts company that recently received its license to offer health insurance products in the District of Columbia. In accordance with DC filing requirements, the product filing for this Student Health Insurance PPO Plan, including the Certificate of Insurance Form, will be submitted as a separate filing at a later date.

If you have any questions regarding this rate filing, please contact Paul Hatch, Manager, Contract Development and Product Compliance, at Tufts Health Plan in Watertown, MA. My direct phone number is 617-923-5665.

Thank you.

## Company and Contact

### Filing Contact Information

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### Filing Company Information

Tufts Insurance Company
705 Mount Auburn Street
Watertown, MA 02472-1508
(617) 972-9400 ext. [Phone]

CoCode: 60117
Group Code:
Group Name:
FEIN Number: 04-3319729

State of Domicile: Massachusetts
Company Type:
State ID Number:

## Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *THPC-129352109* | ***State Tracking #:*** | | ***Company Tracking #:*** | *2013-DC-010* |

| | | | |
|---|---|---|---|
| ***State:*** | *District of Columbia* | ***Filing Company:*** | *Tufts Insurance Company* |
| ***TOI/Sub-TOI:*** | *H04 Health - Blanket Accident /Sickness/H04.001 Student* | | |
| ***Product Name:*** | *DC Student Health PPO - Rate Filing* | | |
| ***Project Name/Number:*** | */2013-DC-010* | | |

## Rate Information

Rate data applies to filing.

| | |
|---|---|
| **Filing Method:** | SERFF |
| **Rate Change Type:** | Neutral |
| **Overall Percentage of Last Rate Revision:** | 0.000% |
| **Effective Date of Last Rate Revision:** | 02/01/2014 |
| **Filing Method of Last Filing:** | Not Applicable |

### Company Rate Information

| Company Name: | Company Rate Change: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | Number of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where req'd): | Minimum % Change (where req'd): |
|---|---|---|---|---|---|---|---|---|
| Tufts Insurance Company | New Product | 0.000% | 0.000% | $0 | 0 | $0 | 0.000% | % |

***State:*** *District of Columbia* ***Filing Company:*** *Tufts Insurance Company*
***TOI/Sub-TOI:*** *H04 Health - Blanket Accident /Sickness/H04.001 Student*
***Product Name:*** *DC Student Health PPO - Rate Filing*
***Project Name/Number:*** */2013-DC-010*

# Rate Review Detail

**COMPANY:**

Company Name: Tufts Insurance Company
HHS Issuer Id: 00000

**PRODUCTS:**

| Product Name | HIOS Product ID | HIOS Submission ID | Number of Covered Lives |
|---|---|---|---|
| DC Student Health Insurance PPO Plan | | | 1 |

Trend Factors:

**FORMS:**

New Policy Forms: DC-PPO-001 Ed. 1-2014
Affected Forms:
Other Affected Forms:

**REQUESTED RATE CHANGE INFORMATION:**

Change Period: Annual
Member Months: 0
Benefit Change: None
Percent Change Requested: Min: Max: Avg:

**PRIOR RATE:**

Total Earned Premium:
Total Incurred Claims:
Annual $: Min: Max: Avg:

**REQUESTED RATE:**

Projected Earned Premium: 0.00
Projected Incurred Claims: 0.00
Annual $: Min: 0.00 Max: 0.00 Avg: 0.00

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *THPC-129352109* | ***State Tracking #:*** | | ***Company Tracking #:*** | *2013-DC-010* |

| | | | |
|---|---|---|---|
| ***State:*** | *District of Columbia* | ***Filing Company:*** | *Tufts Insurance Company* |
| ***TOI/Sub-TOI:*** | *H04 Health - Blanket Accident /Sickness/H04.001 Student* | | |
| ***Product Name:*** | *DC Student Health PPO - Rate Filing* | | |
| ***Project Name/Number:*** | */2013-DC-010* | | |

# Rate/Rule Schedule

| Item No. | Schedule Item Status | Document Name | Affected Form Numbers (Separated with commas) | Rate Action | Rate Action Information | Attachments |
|---|---|---|---|---|---|---|
| 1 | | Rate Manual | DC-PPO-001 Ed. 1-2014 | New | | CHRISTIE STUDENT HEALTH PLANS RATE MANUAL DC.pdf, |

# CHRISTIE STUDENT HEALTH PLANS

**Christie Student Health Plans LLC (CHSP) is an affiliate of Tufts Insurance Company (TIC). CSHP is a subsidiary of TIC's parent company, Tufts Associated Health Plans, Inc.**

## Student Accident and Sickness Insurance

## Rate Manual

**DC-PPO-001 Ed. 1-2014**

THP

# CHRISTIE STUDENT HEALTH PLANS

## Student Accident and Sickness Insurance

## Rate Manual Pages

## Table of Contents

## SECTION I

# INTRODUCTION
## Student Accident and Sickness Insurance

Colleges and universities that provide student health insurance coverage to their students and their dependents typically choose one vendor to be the underwriter/carrier of the coverage. While some similarities may be made to group insurance, student health costs, and the concomitant insurance rates, are influenced by a variety of health cost drivers not generally applicable to group insurance and their effect on health care costs can vary dramatically from institution to institution.

Christie Student Health underwrites health insurance programs offered by colleges and universities to their students and their dependents. We require that Christie Student Health is being offered as the sole carrier. Students and dependents generally bear the entire cost of the insurance premium, although the premium for some subsection of the student population, graduate assistants in particular, may be partially or fully subsidized by the institution. As determined by the institution, enrollment in the health insurance program may be mandatory or mandatory with waiver process (hard waiver enrollment). Mandatory enrollment means all eligible students are automatically enrolled and this requirement generally applies only to full-time students or to a subsection of the student population such as international students. Mandatory with waiver process means all eligible students are automatically enrolled but can waive participation in the program if they can provide proof of acceptable alternative coverage.

The institution defines who is eligible to participate in the health insurance program. In general, for students, the institution will define eligibility as all students who are registered and actively participating in credit courses leading to a degree.

The student health insurance program is a complement to the services provided at the institution's student health center. Most services provided at the health center are those that otherwise would be provided in the community and be covered under the insurance program. As a result, the capabilities of the health center, the scope and depth of its services, be it limited to certain primary care services or expanded beyond primary care to include certain specialty care, is going to directly affect the utilization of services in the community that would otherwise fall under the insurance program. How all of this affects the cost of health care under the insurance program depends not only on the scope and depth of services at the student health center, but how medical services rendered at the health center are financed (i.e., a separate student health fee or fee-for-services charges to the insurance program).

Student Health Insurance Premium Rates are determined by an experience-rating methodology. No manual rate calculation is involved as we believe it is not possible to develop a manual rating system that can adequately address all the variances in risk profile that each institution's student health insurance plan presents. Experience rating is used for all schools, regardless of the size of its insured student population.

Policy / School year experience is used in the experience-rating process when available. Use of the most recent 12 months of paid claims is generally not advisable because of the potential discontinuities that the annual enrollment process can introduce to the payment process, as well as the lack of reliability in the enrollment numbers for the more recent months.

The most recent policy year experience is used in the experience-rating process for institutions with larger insured populations and the two most recent policy years' experience is used for institutions with the smaller insured populations.

## SECTION II

# OUTLINE of COVERAGE

Student accident and health insurance is a policy of hospital, medical and surgical expense insurance. It is written as a Preferred Provider Organization (PPO) Plan.

Student accident and health insurance provides coverage for essential health benefits as defined in Section 1302 (b) and (c) of the Affordable Care Act.

No deductible or cost sharing applies for preventive care visits / services as defined in Section 2713 of the Affordable Care Act.

The deductible is over a policy (school) year.

## SECTION III

## GENERAL UNDERWRITING RULES

Covered Groups: institutions of higher learning

Eligibility: individual enrolled as a student in pursuit of a degree at an institution of higher learning

Enrollment: mandatory or mandatory with waiver

Minimum Number of Insured Students per Institution: 300

Minimum Level of Coverage: benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan

## Section IV

# NEW BUSINESS / RENEWAL CALCULATION

Required data with respect to the institution's student health insurance plan:

- Current Policy Year Premium Rate(s)
- Paid Claims Reports for the immediate past three Policy Years
- Premium for the immediate past three Policy Years broken down by billing tier
- Members by billing tier for the immediate past three Policy Years
- Premium Rates for the immediate past three Policy Years
- Benefit Plan Changes for the immediate past two Policy Years
- Catastrophic Claim Data and Diagnosis for the immediate past three Policy Years
- Insurance Plan Brochures for the current and the immediate past two Policy Years

Experience Rating Process (New Business and Renewal)

Part I

Experience Rating Process for New Business with policy year earned premium equal or greater than $2,500,000

Determine Baseline Loss Ratio (BLR) – A baseline loss ratio is determined for the immediate past policy year by first multiplying that policy year's medical paid claims to date by the appropriate completion factor (as described in Table A). An adjustment may be made if the institution is able to provide a claims lag study for prior years.

Any claims exceeding the pooling point (after projected completion of these claims) will have that amount(s) of claim in excess of the pooling point subtracted

out of the overall projected completed claims. The remaining projected claims will then be multiplied by the Pooling Adjustment factor (Table B).

Generally, outpatient prescription drugs claims for the immediate past policy year are considered complete at the time of calculation (at least three months or more since the end of that policy year. The completed outpatient prescription drugs claims are also adjusted for pooling as described in the prior paragraph.

The completed medical and drug claims are added together and divided by the earned premium to determine the Baseline Loss Ratio for the immediate past Policy Year.

Trend (T) – Trend (Table C), which accounts for changes in unit cost and utilization of services between the immediate past policy year and the current policy year, is applied to the Baseline Loss Ratio. An adjustment may be made by the Underwriter based on the specific claims experience, benefit plan design, network utilization and services provided at the health center.

Benefit Plan Design Change(s) (PDC) – If applicable (i.e. there were benefit plan changes in the current policy year), the appropriate credit or debit is applied to the Baseline Loss Ratio (Table E).

Premium Increase (PI) – If applicable (i.e. there was a premium rate increase or decrease in the current policy year), the appropriate credit or debit is applied to the Baseline Loss Ratio.

Projected Loss Ratio for the Current Policy Year (PLRCY) is determined as follows:

$$[BLR *(1+T) *(1+PDC)] / (1+PI) = PLRCY$$

Trend (T) – Trend (Table C), which accounts for changes in unit cost and utilization of services between the current policy year and the subsequent policy year (the rating period), is applied to the Projected Loss Ratio for the Current Year. An adjustment may be made by the Underwriter based on the specific claims experience, benefit plan design, network utilization and services provided at the health center.

Network Adjustment (NA) – Based on plan utilization and the geographic location of the institution, the underwriter may adjust the Projected Loss Ratio for the Current Year for differences in discounts between the plan's current network and the proposed network.

Actuarial Adjustment/New Business (AA) – If applicable, adjust the Projected Loss Ratio for the Current Year by the appropriate Actuarial Adjustment Factors (Table F).

Projected Loss Ratio for the Subsequent Policy Year (PLRSPY) is determined as follows:

$$[PLRCY*(1+T)*(1+NA)*(1+AA)] = PLRSPY$$

Medical Cost Ratio (MCR) – The Medical Cost Ratio varies by the student health insurance plan's premium size (Table D).

Required Rate Change (RRC) is determined as follows:

$$(PLRSPY/ MCR) - 1 = RRC$$

Part II

Experience Rating Process for New Business with policy year earned premium less than $2,500,000

Determine Baseline Loss Ratio for the Second Prior Policy Year (BLRSPPY) in the same manner as the Baseline Loss Ratio above.

Trend the Baseline Loss Ratio for the Second Prior Policy Year forward one year, to the immediate past policy year.

Determine a Composite Baseline Loss Ratio (CBLR) by equally weighting the Baseline Loss Ratio for the Second Prior Policy Year with the Baseline Loss Ratio as follows:
50% * (BLRSPPY) + 50% * (BLR) = CBR

Note: Significant changes from the second prior policy year to the immediate prior policy year at the institution, the health center or in the insurance plan may dictate greater weighting (credibility) be assigned to the immediate prior policy year.

Repeat the remaining steps in Part I.

## Table A

### Accident and Sickness Claims Completion Methodology

Premium rates for student health insurance programs are determined from an experience rating process using policy year experience. Generally, it takes 14-18 months from the end of the policy year for medical claims (2-5 months for outpatient prescription drugs) to reach the ultimate (or completed) paid level for that experience period.

For student health insurance, renewal rating is done for the second subsequent policy year and is performed 2-8 months after the end of the immediate past policy year. Consequently, a completion factor is required to convert medical claims paid-to-date to our best estimate of completed claims for that policy year. Generally, outpatient prescription drugs are considered to be complete at the time of the renewal calculation.

Were we an ongoing operation with a credible claims database, we would determine the completion factor using the institution's prior claims experience as well as the claims experience of several other institutions with a similar policy year effective date, demographics and benefit plan design. We would incorporate the experience of other institutions because we find using only one observation is not credible and produces inconsistent results. We would use the institution's prior claims experience and the experience of three to five comparable institutions to develop an average completion factor, removing any obvious outliers from the calculation.

In rating prospective business, we would incorporate the institution's historical payment patterns into the development of an appropriate completion factor if it is provided. Otherwise, we would use the same approach to develop a completion factor for prospective business as we do for renewal business, as described above, except that we would rely entirely on the experience of comparable institutions from our book-of-business.

At this juncture, we have not underwritten any student health plans and, therefore, have no prior claims experience. For the immediate future, in situations where we are unable to obtain an institution's historical payment patterns, we will use the table below to complete the medical claims.

| Months from Inception | Completion Factor |
|---|---|
| 1 | .017 |
| 2 | .053 |
| 3 | .104 |
| 4 | .176 |
| 5 | .244 |
| 6 | .325 |
| 7 | .416 |
| 8 | .504 |
| 9 | .594 |
| 10 | .690 |
| 11 | .767 |
| 12 | .847 |
| 13 | .906 |
| 14 | .941 |
| 15 | .957 |
| 16 | .966 |
| 17 | .976 |
| 18 | .982 |
| 19 | .987 |
| 20 | .990 |
| 21 | .993 |
| 22 | .994 |
| 23 | .995 |
| 24 | .996 |
| 25 | .996 |
| 26 | .997 |
| 27 | .997 |
| 28 | .998 |
| 29 | .999 |
| 30 | 1.00 |

## Table B

### Pooling Adjustment Tables*

Standard pooling levels determined by projected paid premium per policy year

| Premium Level | Pooling Level |
|---|---|
| $250,000 to $2,499,999 | $100,000 |
| $2,500,000 to $7,499,999 | $150,000 |
| $7,500,000 to 14,999,999 | $200,000 |
| $15,000,000+ | $250,000 |

| Pooling Level = $100,000 | |
|---|---|
| Plan Maximum | Pooling Charge |
| $150,000 | 1.5% |
| $200,000 | 2.7% |
| $250,000 | 3.6% |
| $300,000 | 4.3% |
| $350,000 | 4.7% |
| $400,000 | 4.9% |
| $500,000 | 5.1% |
| $750,000 | 5.4% |
| $1,000,000 | 5.6% |
| $2,000,000+ | 6.0% |

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| Pooling Level = $150,000 | |
|---|---|
| $200,000 | 1.2% |
| $250,000 | 2.1% |
| $300,000 | 2.7% |
| $350,000 | 3.2% |
| $400,000 | 3.4% |
| $500,000 | 3.6% |
| $750,000 | 3.9% |
| $1,000,000 | 4.1% |
| $2,000,000+ | 4.4% |

| Pooling Level = $200,000 | |
|---|---|
| $250,000 | .9% |
| $300,000 | 1.5% |
| $350,000 | 2.0% |
| $400,000 | 2.2% |
| $500,000 | 2.4% |
| $750,000 | 2.7% |
| $1,000,000 | 2.9% |
| $2,000,000+ | 3.2% |

| Pooling Level = $250,000 | |
|---|---|
| $300,000 | .6% |
| $350,000 | 1.1% |
| $400,000 | 1.3% |
| $500,000 | 1.5% |
| $750,000 | 1.8% |
| $1,000,000 | 2.0% |
| $2,000,000+ | 2.3% |

*THP reserves the right to revise the above values as emerging experience dictates.

## Table C

### Medical and Prescription Drug Trend

The Medical Trend factor is a trend factor derived from our Book-of-Business claims experience that is intended to be applied to current claims experience to project future claims experience. The medical trend factor is adjusted to reflect region-specific cost differentials.

We are a predominantly large case underwriter where, for many institutions, a majority of medical services are rendered at one or two major facilities (and their associated physician group practices) and where these providers are either in the network or have a direct arrangement with the incumbent carrier. Facility costs represent the major portion of the medical costs of an institution's insurance program because the institution's health center typically absorbs most of the primary care costs and acute conditions are dominant for this insured population. In experience rating these institutions, rather than relying only on a trend based on average experience across our block of business, we develop institution-specific medical trend. We do this by incorporating the known and anticipated unit cost increases for a specific provider(s), combined with an assumed increase in utilization. Medical costs from all other providers are trended by a factor based on average experience across our block of business. These medical trends are then weighted based on the percentage each provider represents relative to the total medical costs under the program.

The Outpatient Prescription Drug Trend factor is a trend factor derived from our Book-of-Business claims experience. For student health insurance, prescription drug utilization by therapeutic class and by generic drug penetration is quite uniform from institution to institution.

The Composite Trend for the medical and outpatient prescription drug programs is calculated by weighting the medical and prescription drug trends by the percentage each program represents relative to the total medical costs under the program.

## Table C-1

### Example of the Development of Facility-Specific Medical Trend

| | 2012/2013 – 2013/2014 |
|---|---|
| Unit Cost Increase | 7% |
| Increase in Utilization | 4% |
| **Facility-Specific Trend** | **11%** |

| | 2013/2014 – 2014/2015 |
|---|---|
| Unit Cost Increase | 6% |
| Increase in Utilization | 4% |
| **Facility-Specific Trend** | **10%** |

This facility has a contracted 7% unit cost increase from 2012/2013 (policy year) to 2013/2014 and a 6% unit cost increase from 2013/2014 to 2015. The assumed increase in utilization is 4% for each policy year.

## Table C-2

# Trend Development

An example of the development of institution-specific trend for an insurance program with one major facility and its associated physician group practice.

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Policy Year | | Policy Year | |
| | **Medical Trend** | | | | | |
| | | | **2013/2014** | | **2014/2015** | |
| | | | | **Trend as % of** | | **Trend as % of** |
| | | **% of Medical Plan** | **Trend Used** | **Medical Plan** | **Trend Used** | **Medical Plan** |
| | Main Facility | 50.0% | 8.0% | 4.0% | 8.5% | 4.3% |
| | Physician Group | 10.0% | 5.5% | 0.6% | 5.8% | 0.6% |
| | All Other Medical | 40.0% | 9.0% | 3.6% | 8.0% | 3.2% |
| | | | | 8.2% | | 8.0% |
| | **Medical as a % of Total Plan Costs** | | **88%** | | | |
| | **Final Medical Trend** | | **2013/2014** | | **7.2%** | |
| | | | **2014/2015** | | **7.1%** | |
| | **Prescription Drug Trend** | | | **2013/2014** | | **2014/2015** |
| | Prescription Drug as a % of Total Plan Costs | | | 12% | | 12% |
| | Prescription Drug Trend | | | 9.80% | | 9.40% |
| | **Final Drug Trend** | | | **2013/2014** | | **1.2%** |
| | | | | **2014/2015** | | **1.1%** |
| | **Final Plan Trend** | | | **2013/2014** | | **8.4%** |
| | (Add Medical and Drug Trend) | | | **2014/2015** | | **8.2%** |

## Table D

### Medical Loss Ratio

| Expected Premium (Case Size) | Medical Loss Ratio |
|---|---|
| $250,000 - $999,999 | 76% |
| $1,000,000 - $2,499,999 | 78% |
| $2,500,000 - $4,999,999 | 80% |
| $5,000,000 - $9,999,999 | 81% |
| $10,000,000 or Higher | 82% |

## Table E-1

### Plan Design Changes*

### Change in Plan Annual Deductible

| For Medical Costs Only | |
|---|---|
| | |
| Deductible | Savings |
| 25 | 0.8% |
| 50 | 1.4% |
| 75 | 2.1% |
| 100 | 2.8% |
| 200 | 5.4% |
| 300 | 7.8% |
| 400 | 10.0% |
| 500 | 12.0% |
| 600 | 13.8% |
| 700 | 15.4% |
| 800 | 16.8% |
| 900 | 18.0% |
| 1,000 | 19.0% |
| 1,500 | 23.5% |
| 2,000 | 27.5% |
| 2,500 | 31.0% |

Note: Any difference between plan deductibles is calculated as the difference in savings. For example, increasing the annual deductible from $100 to $300 is a savings of 5.0% (7.8% - 2.8%).

*THP reserves the right to revise the above values as emerging experience dictates

## Table E-2

### Plan Design Changes

## Change in Copays and Coinsurance

For renewal calculations of institutions with plan premiums greater than $2,500,000, we determine the actual cost/savings of each plan change based on the individual benefits affected for the specific institution.

For example, the cost/savings for a change in copay for a physician office visit, emergency room, physical therapy, chiropractic or outpatient mental health is determined by multiplying the dollar change by the average of the total number of visits for that specific benefit for the past two policy years.

For a change in coinsurance, the cost/savings is determined by multiplying the percentage increase/decrease in coinsurance by the percentage that claims subject to that coinsurance level represents relative to the total costs of the program.

For institutions with plan premiums less than $2,500,000 or for new business, we use a larger institution as a proxy to develop our best estimate for the plan change, taking into account the differences in covered populations.

## Table F-1

### Actuarial Adjustment / New Business

| Criteria | Preferred Factor | Definition | | Undesirable Factor | Definition |
|---|---|---|---|---|---|
| | | | | | |
| Loss Ratio | Up to -2% | LT or equal to 80% | | Up to 2% | greater than 80% |
| Completeness of Information | Up to -2% | all required Data | | Up to 2% | incomplete Loss Data |
| Carrier Persistency | Up to -2% | 2 or less carriers past 5 years | | Up to 2% | More than 2 carriers |
| Enrollment/Participation Levels | Up to -2% | Consistent or increase | | Up to 2% | Below average |
| Network Utilization | Up to -2% | Greater than 80% | | Up to 2% | Less than 85% |
| Administrative Complexity | Up to -2% | Less than average | | Up to 2% | Greater than average |
| Change in Referral Patterns | Up to -2% | Adding a referral requirement | | Up to 2% | Decrease in referral requirement |
| Change in Staffing at SHC | Up to -2% | Increase in staffing or services | | Up to 2% | Decrease in staffing or services |

Note: maximum discount for all factors combined is 5%.

## Table F-2

### Actuarial Adjustment / New Business

### Student Health Insurance Plans that have significant changes in enrollment

| Enrollment | Factor |
|---|---|
| Mandatory with Waiver | 1.00 |
| Mandatory | .85 |
| | |
| **Student Status** | |
| Undergraduate | 1.00 |
| Graduate | 1.70 |
| Professional | 2.00 |
| | |
| **Student Status** | |
| Domestic | 1.00 |
| International | .80 |

## Table G

## Pediatric Dental Care**

| | In-Network Level | Out-of-Network Level |
|---|---|---|
| Annual Deductible (per person) | Not applicable | $50 |
| Coverage (Class) Type | % of fee paid | % of fee paid |
| Basic Coverage (Class A) | 100% | 90% |
| Intermediate Coverage (Class B) | 70% | 60% |
| Major Coverage (Class C) | 50% | 40% |
| Medically Necessary Orthodontia (Class D) | 50% | 50% |

## Pediatric Vision Care**

| | In-Network Level | Out-of-Network Level |
|---|---|---|
| Annual Deductible (per person) | Not applicable | Not applicable |
| Coverage Type | % of fee paid | % of fee paid |
| Diagnostic | 100% | fee schedule |
| Eyewear | | |
| Lenses | 100% | fee schedule |
| Frame Collection | 100% | fee schedule |
| Frame Non-Collection | $150 allowance | fee schedule |
| Contact Lenses | $150 allowance | fee schedule |

| | Dental | Vision |
|---|---|---|
| Projected Average Cost for Eligible Insured Students 2014-2015 Policy Year | $352 | $118 |
| Multiply by: | | |
| Proportion of Insured Members Under age 19 to the Insured Member Population | XX% | XX% |
| Divide by: | | |
| Medical Cost Ratio | 82% | 82% |
| Annual Premium per Insured Student: | | |

*For many institutions of higher learning, demographic information by age is available on the institution's website. Alternatively, 22-24% of undergraduates will be covered under the student health insurance plan with mandatory with waiver enrollment process. Freshmen (as a proxy to under age 19) typically represent 20% of the insured undergraduates.

**THP reserves the right to revise the above values as emerging experience dictates.

## Table H

### Second Year Premium Rate Cap

When an institution puts its student health plan out to bid for a given year, it generally requires that a cap on the rate increase for the subsequent plan year also be provided in the bid. The institution makes this requirement to preclude any bidding carrier from being overly aggressive in pricing the first year with the intent of rebalancing the premium rate with a large increase in the second year. From the carrier's perspective who is awarded the business for the first time, this requirement is not unreasonable because that carrier at the time to renew for the second year will only have about three months of claims experience from the first year, a baseline that is insufficient for experience rating.

The rate cap for the second year generally reflects the carrier's best estimate of trend for the renewal year. The underlying premise for a rate cap is that the carrier properly priced the plan in the first year and only a trend increase in needed in the second year. A margin of two to three points is generally added to the trend estimate to provide the carrier with some flexibility should the carrier's best estimate of trend change adversely in between the time the rate cap is quoted and the second year renewal is finalized, usually a period of about twelve months.

# Standard University

## 2014-15 Student Health Insurance Plan

## Retrospective Premium Agreement (Sample)

This Letter of Agreement (the "Agreement"), effective as of August XX, 2014, serves to document our mutual understanding and agreement of the circumstances under which Standard University would be entitled to return of potential premium surplus, based on claims experience, under Student Accident and Sickness Insurance Policy (Policy # XXXXXXXX) (the "Policy") between Standard University (the "Policyholder") and Tufts Health Plan (the "Company").

1. The retrospective premium agreement described in this Agreement will apply only to the 2014-2015 Policy Year. The agreement will apply to the Student Health Insurance Plan, the Dependent and Continuation coverage (if applicable) on a combined basis. The premium and claims associated with Accidental Death and Dismemberment, Worldwide Emergency Travel Assistance, and Medical Evacuation and Return of Mortal Remains will be excluded.
2. Retrospective Premium Calculation. For the aforementioned Policy Year and subject to the terms set below, the Company will perform a retrospective premium calculation twelve (12) months after the end of that Policy Year.
3. Incurred Claims. Incurred claims for that Policy Year will be defined as follows: total paid claims to date for that Policy Year completed to ultimate by means of an appropriate completion factor and then modified by the appropriate pooling adjustment. (Amounts in excess of the pooling point on individual claimants are removed and a pooling charge is applied. The pooling point and the corresponding pooling charge for that Policy Year will be the ones that otherwise would have applied to that Policy Year and used to prospectively rate the second subsequent renewal Policy Year).

4. Earned Premium. Earned premium for that Policy Year will be defined as follows: premium billed and due and remitted for the coverage provided with respect to that Policy Year.
5. Incurred Loss Ratio. An incurred loss ratio for that Policy Year will be defined as follows: incurred claims divided by earned premium (expressed to 3 decimal places).
6. Surplus. If the incurred loss ratio is less than .XXX (expressed to 3 decimal places), then a surplus is created; if the incurred loss ratio is equal to or greater than .XXX, there is no retrospective premium adjustment.
7. Refund. If a surplus is created, the refund is equal to: (A) X (B) X (C) where
   (A) is the absolute difference between the incurred loss ratio and .XXX
   (B) Is the earned premium for the 2014-2015 Policy Year
   (C) the University will receive XX% of the surplus below .XXX
8. Payment of Refund. The refund will be remitted to the Policyholder within 30 days of the date of the calculation provided the Policy remains in force through Policy Year 2014-2015. If the Policy terminates earlier, there will be no refund.
9. Use of Refund. Any and all refunds will be returned to the Policyholder. Upon request by the Policyholder, part or all of it will be applied against the payment of premiums as may be agreed to by the Policyholder and the Company. If the sum of student contributions which have been made for insurance exceeds the sum of premiums which have been paid for insurance (after giving effect to any refund), the excess will be applied by the Policyholder for the sole benefit of students. The Company will not have to see to the use of such excess.

If you are in agreement with the terms of this Agreement, please sign both copies and return one to me on or before August XX, 2014. Failure to return an executed copy of the Agreement prior to that date shall render this Agreement null and void.

THP

Signed: Tufts Health Plan Representative

Name: _____ ___/___/___

Date

Title: _____

Signed: Standard University Representative

Name: _____ ___/___/___

Date

Title: _____

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *THPC-129352109* | ***State Tracking #:*** | | ***Company Tracking #:*** | *2013-DC-010* |

| | | | |
|---|---|---|---|
| ***State:*** | *District of Columbia* | ***Filing Company:*** | *Tufts Insurance Company* |
| ***TOI/Sub-TOI:*** | *H04 Health - Blanket Accident /Sickness/H04.001 Student* | | |
| ***Product Name:*** | *DC Student Health PPO - Rate Filing* | | |
| ***Project Name/Number:*** | */2013-DC-010* | | |

## Supporting Document Schedules

| | |
|---|---|
| **Satisfied - Item:** | Cover Letter  All Filings |
| **Comments:** | The required cover letter is attached below. |
| **Attachment(s):** | Cover Letter - DC Rate Filing (12-24-13).pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Certificate of Authority to File |
| **Bypass Reason:** | Not applicable.  This filing is being submitted by Tufts Insurance Company, which will be the insurer for this product. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Actuarial Memorandum |
| **Comments:** | Attached below are the actuarial memorandum and rate manual for this rate filing submission. |
| **Attachment(s):** | Actuarial Memorandum DC .pdf<br>CHRISTIE STUDENT HEALTH PLANS RATE MANUAL DC.pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Actuarial Justification |
| **Comments:** | This requirement is addressed in Actuarial Memorandum attached above within this Supporting Documentation tab.<br><br>Please note that this submission is being filed as a rate filing.  A separate form filing will be submitted subsequently for this Student Health Insurance PPO product. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | District of Columbia and Countrywide Loss Ratio Analysis (P&C) |
| **Bypass Reason:** | Not applicable to this initial rate filing submission. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | District of Columbia and Countrywide Experience for the Last 5 Years (P&C) |
| **Bypass Reason:** | Not applicable to this initial rate filing submission. |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *THPC-129352109* | ***State Tracking #:*** | | ***Company Tracking #:*** | *2013-DC-010* |

| | | | |
|---|---|---|---|
| ***State:*** | *District of Columbia* | ***Filing Company:*** | *Tufts Insurance Company* |
| ***TOI/Sub-TOI:*** | *H04 Health - Blanket Accident /Sickness/H04.001 Student* | | |
| ***Product Name:*** | *DC Student Health PPO - Rate Filing* | | |
| ***Project Name/Number:*** | */2013-DC-010* | | |

| | |
|---|---|
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Consumer Disclosure Form |
| **Bypass Reason:** | Not applicable to this initial rate filing submission. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Actuarial Memorandum and Certifications |
| **Bypass Reason:** | Not applicable to this initial rate filing submission. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Unified Rate Review Template |
| **Bypass Reason:** | Not applicable to this initial rate filing submission. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

TUFTS Health Plan

**Corporate Office**
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02471-9170
(617) 972-9400
www.tuftshealthplan.com

December 24, 2013

District of Columbia
Department of Insurance, Securities & Banking
810 First Street, NE, Suite 701
Washington, DC 20002

Re: Student Accident and Sickness Rate Manual
Tufts Insurance Company
NAIC Number 60117
TIC Filing # 2013-DC-010
SERFF Tracking # THPC-129352109
PPO Certificate Form # DC-PPO-001 Ed. 1-2014

Dear Commissioner:

Christie Student Health Plans LLC (CSHP) is an affiliate of Tufts Insurance Company (TIC). CSHP is a subsidiary of TIC's parent company, Tufts Associated Health Plans, Inc. Tufts Associated Health Plans, Inc. has a majority ownership interest in CSHP.

This is a rate filing with a proposed effective date of February 1, 2014 and is being filed in conjunction with PPO Certificate Form DC-PPO- 001 Ed. 1-2014 which will be filed later.

Since this is a new filing, there currently are no policyholders in the District of Columbia. The premium and rating information for this new product are addressed in the actuarial memorandum and rate manual that accompany this letter.

Your prompt attention to this submission will be appreciated. If there are any questions, please do not hesitate to contact us.

Sincerely,

Paul W. Hatch, M.B.A.
Manager, Benefit Contract Development and Product Compliance
Tufts Health Plan – Legal Department

Phone: 617-923-5665
Email: paul_hatch@tufts-health.com

# Actuarial Memorandum

**Christie Student Health Plans LLC**

**Actuarial Memorandum Supporting Christie Student Health Plan's Student Accident and Sickness Rate Manual**

**Rate Filing for PPO Certificate Form DC-PPO-001 Ed. 1-2014**

1. Background

Christie Student Health Plans LLC (CSHP) is an affiliate of Tufts Insurance Company (TIC). CSHP is a subsidiary of TIC's parent company, Tufts Associated Health Plans, Inc. Tufts Associated Health Plans, Inc. has a majority ownership interest in CSHP.

CSHP specializes in providing underwriting services for health insurance programs offered by colleges and universities to their students and their dependents. At this time, CSHP has not provided underwriting services for any student health insurance programs and has no claims data specific to student health.

2. Scope and Purpose

The purpose of this actuarial memorandum is to present the rating methodology and supporting information related to this new product filing.

3. Description of Benefits

The policy being filed is a comprehensive major medical PPO plan that will be sold to institutions of higher learning. The policy will cover eligible students enrolled at the institution and their covered dependents.

This policy is designed to be compliant with PPACA and HHS regulations.

4. Renewability Provision

The policy is a non-renewable one-year contract.

5. Applicability

This filing applies to all newly insured students and their dependents under the above referenced policy form.

6. Marketing Method

This product is sold through company-employed licensed agents and brokers.

7. Underwriting Method

There is no medical underwriting of individuals. Each institution's student health insurance plan is underwritten to take into account all relevant known factors: past claims experience; size; benefit design of the plan and any other factors relevant to the expected cost of insurance for the particular institution's plan. Recent past experience is a most important underwriting factor, The experience rating methodology is described in the attached Student Accident and Sickness Insurance Rate Manual.

8. Issue Age Limits

There are no minimum or maximum issue ages.

9. Premium Basis

Premiums are stated as annual. Premiums may be split by semester or by some other partition of the year as chosen by the institution of higher learning.

10. Nature of Rate Change and Proposed Rate/Methodology Change

This is a new product filing.

11. Overall Premium Impact of Filing on DC Policyholders

Since this a new product filing, there are currently no policyholders in the District of Columbia.

12. Filed Minimum Required Loss Ratio

We anticipate that student health insurance plans will likely be required to meet an MLR target of 75%. CSHP intends to market to the larger plans in the student health marketplace and expects its combined medical loss ratio to equal or exceed 80%.

13. Interest Rate Assumptions

No interest rate assumption is used in pricing this product.

14. Trend Assumptions

Student health insurance plans for most institutions of higher learning utilize a very limited number of providers of medical services in a plan year. For most plans, future changes in unit costs for these providers are known to the underwriter and are used to develop trend factors

specific to each plan in projecting future claims cost for that plan. In addition, we expect to use Tufts Health Plan's data when appropriate and published indexes of medical and pharmacy trend.

15. Persistency

Persistency is not used in pricing this product.

## Student Accident and Sickness Insurance Rate Manual

CSHP currently has no student health claims database. The rating factors, assumptions and methodologies in the CSHP's Student Accident and Sickness Rate Manual were developed from three sources: my personal knowledge and experience, publicly-available carrier information and Tufts Health Plan's claims data.

Section I (Introduction) provides an explanation for the preferred use of experience rating to determine premium rates for student health plans.

Section II (Outline of Coverage) indicates CSHP's intent to offer coverage that meets state and federal requirements.

Section III (General Underwriting Rules) lists criteria that are considered to be standard for student health insurance. The minimum of 300 lives was chosen to provide credibility to the experience rating methodology and to have an expense ratio that is both self-supporting and meets minimum loss ratio requirements.

Section IV (New Business / Renewal Calculation) describes the experience rating methodology which I believe is consistent with other experience rating methodologies used in the student health and large group insurance.

Table A describes the development of completion factors. Unlike group health insurance, student health plans tend to have a run out of claims that extends 14-18 months beyond the end of the plan year and can vary from one plan to the next. When a college or university puts out a Response for a Proposal (RFP), the RFP often includes a historical claims pattern for the institution's student health insurance plan.

Table B (Pooling Adjustment Tables) lists the recommended pooling levels and the associated pooling charges. The pooling charges were developed from a combination of publicly-available carrier information and internal claims data from Tufts Health Plan.

Table C (Medical and Prescription Drug Trend) describes why medical trend tends to be specific to the student health insurance plan and how it is developed.

Table D (Medical Loss Ratio) lists the targeted medical cost ratios by premium size of the student health insurance plan. CSHP intends to market to the larger plans in the student health marketplace and expects its combined medical loss ratio to equal or exceed 80%.

Table E (Plan Design Changes) describes how the financial impact of a change in copay or coinsurance is determined and lists the financial impact of various plan deductible levels. The deductible values were developed from my experience and knowledge and from publicly-available carrier information.

Table F-1 (Actuarial Adjustment / New Business) lists the various aspects of a student health insurance plan that can have a material impact on the plan's claims experience. Table F-2 lists the relative morbidity levels within an insured student population. The factors in both tables are based on my knowledge and experience.

Table G (Pediatric Dental and Vision Care) illustrates how the premium rates for these two benefits are calculated.

Table H (Second Year Premium Rate Cap) defines the circumstances under which a second year rate cap for a student health insurance plan would be offered to an institution and how that rate cap is determined.

Retrospective Premium Agreement. College and university officials who are responsible for the institution's student health insurance plan generally assume a fiduciary responsibility with respect to the plan and the students' premium. While the institution does not want to take on risk that would occur if it became party to a standard retrospective premium agreement, it does want protection from the carrier accruing a windfall in profits in a given year where the plan's actual loss ratio comes in significantly below the target loss ratio. This retrospective premium agreement addresses this concern. Excess surplus is returned but there is no deficit recovery or carry-over. The threshold for defining excess surplus generally is several loss ratio points below the target loss ratio for the plan to allow the carrier to continue to pool risk to some degree.

Habilitative Services. The cost associated with adding habilitative services is assumed to be of a de minimis level for this insured population. Tufts Health Plan reserves the right to review this assumption as emerging experience dictates.

Qualifications

I, Paul A. Cronin, am a Fellow of the Society of Actuaries (FSA). I am a member of the American Academy of Actuaries (AAA) and meet the qualification standards for actuaries issuing statements of actuarial opinions in the United States. I have also served for thirteen years as head actuary and underwriter of the student health division for a previous employer in the health insurance industry.

This actuarial certification is prepared with respect to CSHP's Student Accident and Sickness Rate Manual which is being filed in conjunction with PPO Certificate Form DC-PPO-001 Ed. 1-2014.

**Actuarial Certification**

I certify that the rating methodology and rating factors contained in Christie Student Health Plan's Student and Accident Rate Manual are appropriate for the prospective rating of student health insurance plans and are reasonable in relation to the benefits provided.

Paul A. Cronin, F.S.A., M.A.A.A.

Actuary

Christie Student Health Plans

December 20, 2013

# CHRISTIE STUDENT HEALTH PLANS

**Christie Student Health Plans LLC (CHSP) is an affiliate of Tufts Insurance Company (TIC). CSHP is a subsidiary of TIC's parent company, Tufts Associated Health Plans, Inc.**

## Student Accident and Sickness Insurance

## Rate Manual

**DC-PPO-001 Ed. 1-2014**

THP

# CHRISTIE STUDENT HEALTH PLANS

## Student Accident and Sickness Insurance

## Rate Manual Pages

## Table of Contents

## SECTION I

# INTRODUCTION
## Student Accident and Sickness Insurance

Colleges and universities that provide student health insurance coverage to their students and their dependents typically choose one vendor to be the underwriter/carrier of the coverage. While some similarities may be made to group insurance, student health costs, and the concomitant insurance rates, are influenced by a variety of health cost drivers not generally applicable to group insurance and their effect on health care costs can vary dramatically from institution to institution.

Christie Student Health underwrites health insurance programs offered by colleges and universities to their students and their dependents. We require that Christie Student Health is being offered as the sole carrier. Students and dependents generally bear the entire cost of the insurance premium, although the premium for some subsection of the student population, graduate assistants in particular, may be partially or fully subsidized by the institution. As determined by the institution, enrollment in the health insurance program may be mandatory or mandatory with waiver process (hard waiver enrollment). Mandatory enrollment means all eligible students are automatically enrolled and this requirement generally applies only to full-time students or to a subsection of the student population such as international students. Mandatory with waiver process means all eligible students are automatically enrolled but can waive participation in the program if they can provide proof of acceptable alternative coverage.

The institution defines who is eligible to participate in the health insurance program. In general, for students, the institution will define eligibility as all students who are registered and actively participating in credit courses leading to a degree.

The student health insurance program is a complement to the services provided at the institution's student health center. Most services provided at the health center are those that otherwise would be provided in the community and be covered under the insurance program. As a result, the capabilities of the health center, the scope and depth of its services, be it limited to certain primary care services or expanded beyond primary care to include certain specialty care, is going to directly affect the utilization of services in the community that would otherwise fall under the insurance program. How all of this affects the cost of health care under the insurance program depends not only on the scope and depth of services at the student health center, but how medical services rendered at the health center are financed (i.e., a separate student health fee or fee-for-services charges to the insurance program).

Student Health Insurance Premium Rates are determined by an experience-rating methodology. No manual rate calculation is involved as we believe it is not possible to develop a manual rating system that can adequately address all the variances in risk profile that each institution's student health insurance plan presents. Experience rating is used for all schools, regardless of the size of its insured student population.

Policy / School year experience is used in the experience-rating process when available. Use of the most recent 12 months of paid claims is generally not advisable because of the potential discontinuities that the annual enrollment process can introduce to the payment process, as well as the lack of reliability in the enrollment numbers for the more recent months.

The most recent policy year experience is used in the experience-rating process for institutions with larger insured populations and the two most recent policy years' experience is used for institutions with the smaller insured populations.

## SECTION II

# OUTLINE of COVERAGE

Student accident and health insurance is a policy of hospital, medical and surgical expense insurance. It is written as a Preferred Provider Organization (PPO) Plan.

Student accident and health insurance provides coverage for essential health benefits as defined in Section 1302 (b) and (c) of the Affordable Care Act.

No deductible or cost sharing applies for preventive care visits / services as defined in Section 2713 of the Affordable Care Act.

The deductible is over a policy (school) year.

## SECTION III

## GENERAL UNDERWRITING RULES

Covered Groups: institutions of higher learning

Eligibility: individual enrolled as a student in pursuit of a degree at an institution of higher learning

Enrollment: mandatory or mandatory with waiver

Minimum Number of Insured Students per Institution: 300

Minimum Level of Coverage: benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan

## Section IV

# NEW BUSINESS / RENEWAL CALCULATION

Required data with respect to the institution's student health insurance plan:

- Current Policy Year Premium Rate(s)
- Paid Claims Reports for the immediate past three Policy Years
- Premium for the immediate past three Policy Years broken down by billing tier
- Members by billing tier for the immediate past three Policy Years
- Premium Rates for the immediate past three Policy Years
- Benefit Plan Changes for the immediate past two Policy Years
- Catastrophic Claim Data and Diagnosis for the immediate past three Policy Years
- Insurance Plan Brochures for the current and the immediate past two Policy Years

Experience Rating Process (New Business and Renewal)

Part I

Experience Rating Process for New Business with policy year earned premium equal or greater than $2,500,000

Determine Baseline Loss Ratio (BLR) – A baseline loss ratio is determined for the immediate past policy year by first multiplying that policy year's medical paid claims to date by the appropriate completion factor (as described in Table A). An adjustment may be made if the institution is able to provide a claims lag study for prior years.

Any claims exceeding the pooling point (after projected completion of these claims) will have that amount(s) of claim in excess of the pooling point subtracted

out of the overall projected completed claims. The remaining projected claims will then be multiplied by the Pooling Adjustment factor (Table B).

Generally, outpatient prescription drugs claims for the immediate past policy year are considered complete at the time of calculation (at least three months or more since the end of that policy year. The completed outpatient prescription drugs claims are also adjusted for pooling as described in the prior paragraph.

The completed medical and drug claims are added together and divided by the earned premium to determine the Baseline Loss Ratio for the immediate past Policy Year.

Trend (T) – Trend (Table C), which accounts for changes in unit cost and utilization of services between the immediate past policy year and the current policy year, is applied to the Baseline Loss Ratio. An adjustment may be made by the Underwriter based on the specific claims experience, benefit plan design, network utilization and services provided at the health center.

Benefit Plan Design Change(s) (PDC) – If applicable (i.e. there were benefit plan changes in the current policy year), the appropriate credit or debit is applied to the Baseline Loss Ratio (Table E).

Premium Increase (PI) – If applicable (i.e. there was a premium rate increase or decrease in the current policy year), the appropriate credit or debit is applied to the Baseline Loss Ratio.

Projected Loss Ratio for the Current Policy Year (PLRCY) is determined as follows:

$$[BLR *(1+T) *(1+PDC)] / (1+PI) = PLRCY$$

Trend (T) – Trend (Table C), which accounts for changes in unit cost and utilization of services between the current policy year and the subsequent policy year (the rating period), is applied to the Projected Loss Ratio for the Current Year. An adjustment may be made by the Underwriter based on the specific claims experience, benefit plan design, network utilization and services provided at the health center.

Network Adjustment (NA) – Based on plan utilization and the geographic location of the institution, the underwriter may adjust the Projected Loss Ratio for the Current Year for differences in discounts between the plan's current network and the proposed network.

Actuarial Adjustment/New Business (AA) – If applicable, adjust the Projected Loss Ratio for the Current Year by the appropriate Actuarial Adjustment Factors (Table F).

Projected Loss Ratio for the Subsequent Policy Year (PLRSPY) is determined as follows:

$$[PLRCY*(1+T)*(1+NA)*(1+AA)] = PLRSPY$$

Medical Cost Ratio (MCR) – The Medical Cost Ratio varies by the student health insurance plan's premium size (Table D).

Required Rate Change (RRC) is determined as follows:

$$(PLRSPY/ MCR) - 1 = RRC$$

Part II

Experience Rating Process for New Business with policy year earned premium less than $2,500,000

Determine Baseline Loss Ratio for the Second Prior Policy Year (BLRSPPY) in the same manner as the Baseline Loss Ratio above.

Trend the Baseline Loss Ratio for the Second Prior Policy Year forward one year, to the immediate past policy year.

Determine a Composite Baseline Loss Ratio (CBLR) by equally weighting the Baseline Loss Ratio for the Second Prior Policy Year with the Baseline Loss Ratio as follows:
50% * (BLRSPPY) + 50% * (BLR) = CBR

Note: Significant changes from the second prior policy year to the immediate prior policy year at the institution, the health center or in the insurance plan may dictate greater weighting (credibility) be assigned to the immediate prior policy year.

Repeat the remaining steps in Part I.

## Table A

### Accident and Sickness Claims Completion Methodology

Premium rates for student health insurance programs are determined from an experience rating process using policy year experience. Generally, it takes 14-18 months from the end of the policy year for medical claims (2-5 months for outpatient prescription drugs) to reach the ultimate (or completed) paid level for that experience period.

For student health insurance, renewal rating is done for the second subsequent policy year and is performed 2-8 months after the end of the immediate past policy year. Consequently, a completion factor is required to convert medical claims paid-to-date to our best estimate of completed claims for that policy year. Generally, outpatient prescription drugs are considered to be complete at the time of the renewal calculation.

Were we an ongoing operation with a credible claims database, we would determine the completion factor using the institution's prior claims experience as well as the claims experience of several other institutions with a similar policy year effective date, demographics and benefit plan design. We would incorporate the experience of other institutions because we find using only one observation is not credible and produces inconsistent results. We would use the institution's prior claims experience and the experience of three to five comparable institutions to develop an average completion factor, removing any obvious outliers from the calculation.

In rating prospective business, we would incorporate the institution's historical payment patterns into the development of an appropriate completion factor if it is provided. Otherwise, we would use the same approach to develop a completion factor for prospective business as we do for renewal business, as described above, except that we would rely entirely on the experience of comparable institutions from our book-of-business.

At this juncture, we have not underwritten any student health plans and, therefore, have no prior claims experience. For the immediate future, in situations where we are unable to obtain an institution's historical payment patterns, we will use the table below to complete the medical claims.

| Months from Inception | Completion Factor |
|---|---|
| 1 | .017 |
| 2 | .053 |
| 3 | .104 |
| 4 | .176 |
| 5 | .244 |
| 6 | .325 |
| 7 | .416 |
| 8 | .504 |
| 9 | .594 |
| 10 | .690 |
| 11 | .767 |
| 12 | .847 |
| 13 | .906 |
| 14 | .941 |
| 15 | .957 |
| 16 | .966 |
| 17 | .976 |
| 18 | .982 |
| 19 | .987 |
| 20 | .990 |
| 21 | .993 |
| 22 | .994 |
| 23 | .995 |
| 24 | .996 |
| 25 | .996 |
| 26 | .997 |
| 27 | .997 |
| 28 | .998 |
| 29 | .999 |
| 30 | 1.00 |

## Table B

### Pooling Adjustment Tables*

Standard pooling levels determined by projected paid premium per policy year

| Premium Level | Pooling Level |
|---|---|
| $250,000 to $2,499,999 | $100,000 |
| $2,500,000 to $7,499,999 | $150,000 |
| $7,500,000 to 14,999,999 | $200,000 |
| $15,000,000+ | $250,000 |

| Pooling Level = $100,000 | |
|---|---|
| Plan Maximum | Pooling Charge |
| $150,000 | 1.5% |
| $200,000 | 2.7% |
| $250,000 | 3.6% |
| $300,000 | 4.3% |
| $350,000 | 4.7% |
| $400,000 | 4.9% |
| $500,000 | 5.1% |
| $750,000 | 5.4% |
| $1,000,000 | 5.6% |
| $2,000,000+ | 6.0% |

THP

| Pooling Level = $150,000 | |
|---|---|
| $200,000 | 1.2% |
| $250,000 | 2.1% |
| $300,000 | 2.7% |
| $350,000 | 3.2% |
| $400,000 | 3.4% |
| $500,000 | 3.6% |
| $750,000 | 3.9% |
| $1,000,000 | 4.1% |
| $2,000,000+ | 4.4% |

| Pooling Level = $200,000 | |
|---|---|
| $250,000 | .9% |
| $300,000 | 1.5% |
| $350,000 | 2.0% |
| $400,000 | 2.2% |
| $500,000 | 2.4% |
| $750,000 | 2.7% |
| $1,000,000 | 2.9% |
| $2,000,000+ | 3.2% |

| Pooling Level = $250,000 | |
|---|---|
| $300,000 | .6% |
| $350,000 | 1.1% |
| $400,000 | 1.3% |
| $500,000 | 1.5% |
| $750,000 | 1.8% |
| $1,000,000 | 2.0% |
| $2,000,000+ | 2.3% |

*THP reserves the right to revise the above values as emerging experience dictates.

## Table C

### Medical and Prescription Drug Trend

The Medical Trend factor is a trend factor derived from our Book-of-Business claims experience that is intended to be applied to current claims experience to project future claims experience. The medical trend factor is adjusted to reflect region-specific cost differentials.

We are a predominantly large case underwriter where, for many institutions, a majority of medical services are rendered at one or two major facilities (and their associated physician group practices) and where these providers are either in the network or have a direct arrangement with the incumbent carrier. Facility costs represent the major portion of the medical costs of an institution's insurance program because the institution's health center typically absorbs most of the primary care costs and acute conditions are dominant for this insured population. In experience rating these institutions, rather than relying only on a trend based on average experience across our block of business, we develop institution-specific medical trend. We do this by incorporating the known and anticipated unit cost increases for a specific provider(s), combined with an assumed increase in utilization. Medical costs from all other providers are trended by a factor based on average experience across our block of business. These medical trends are then weighted based on the percentage each provider represents relative to the total medical costs under the program.

The Outpatient Prescription Drug Trend factor is a trend factor derived from our Book-of-Business claims experience. For student health insurance, prescription drug utilization by therapeutic class and by generic drug penetration is quite uniform from institution to institution.

The Composite Trend for the medical and outpatient prescription drug programs is calculated by weighting the medical and prescription drug trends by the percentage each program represents relative to the total medical costs under the program.

## Table C-1

### Example of the Development of Facility-Specific Medical Trend

| | 2012/2013 – 2013/2014 |
|---|---|
| Unit Cost Increase | 7% |
| Increase in Utilization | 4% |
| **Facility-Specific Trend** | **11%** |

| | 2013/2014 – 2014/2015 |
|---|---|
| Unit Cost Increase | 6% |
| Increase in Utilization | 4% |
| **Facility-Specific Trend** | **10%** |

This facility has a contracted 7% unit cost increase from 2012/2013 (policy year) to 2013/2014 and a 6% unit cost increase from 2013/2014 to 2015. The assumed increase in utilization is 4% for each policy year.

## Table C-2

# Trend Development

An example of the development of institution-specific trend for an insurance program with one major facility and its associated physician group practice.

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Policy Year | | Policy Year | |
| | **Medical Trend** | | | | | |
| | | | **2013/2014** | | **2014/2015** | |
| | | | | **Trend as % of** | | **Trend as % of** |
| | | **% of Medical Plan** | **Trend Used** | **Medical Plan** | **Trend Used** | **Medical Plan** |
| | Main Facility | 50.0% | 8.0% | 4.0% | 8.5% | 4.3% |
| | Physician Group | 10.0% | 5.5% | 0.6% | 5.8% | 0.6% |
| | All Other Medical | 40.0% | 9.0% | 3.6% | 8.0% | 3.2% |
| | | | | 8.2% | | 8.0% |
| | **Medical as a % of Total Plan Costs** | | **88%** | | | |
| | **Final Medical Trend** | | **2013/2014** | | **7.2%** | |
| | | | **2014/2015** | | **7.1%** | |
| | **Prescription Drug Trend** | | | **2013/2014** | | **2014/2015** |
| | Prescription Drug as a % of Total Plan Costs | | | 12% | | 12% |
| | Prescription Drug Trend | | | 9.80% | | 9.40% |
| | **Final Drug Trend** | | | **2013/2014** | | **1.2%** |
| | | | | **2014/2015** | | **1.1%** |
| | **Final Plan Trend** | | | **2013/2014** | | **8.4%** |
| | (Add Medical and Drug Trend) | | | **2014/2015** | | **8.2%** |

## Table D

### Medical Loss Ratio

| Expected Premium (Case Size) | Medical Loss Ratio |
|---|---|
| $250,000 - $999,999 | 76% |
| $1,000,000 - $2,499,999 | 78% |
| $2,500,000 - $4,999,999 | 80% |
| $5,000,000 - $9,999,999 | 81% |
| $10,000,000 or Higher | 82% |

## Table E-1

### Plan Design Changes*

### Change in Plan Annual Deductible

| For Medical Costs Only | |
|---|---|
| | |
| Deductible | Savings |
| 25 | 0.8% |
| 50 | 1.4% |
| 75 | 2.1% |
| 100 | 2.8% |
| 200 | 5.4% |
| 300 | 7.8% |
| 400 | 10.0% |
| 500 | 12.0% |
| 600 | 13.8% |
| 700 | 15.4% |
| 800 | 16.8% |
| 900 | 18.0% |
| 1,000 | 19.0% |
| 1,500 | 23.5% |
| 2,000 | 27.5% |
| 2,500 | 31.0% |

Note: Any difference between plan deductibles is calculated as the difference in savings. For example, increasing the annual deductible from $100 to $300 is a savings of 5.0% (7.8% - 2.8%).

*THP reserves the right to revise the above values as emerging experience dictates

## Table E-2

### Plan Design Changes

## Change in Copays and Coinsurance

For renewal calculations of institutions with plan premiums greater than $2,500,000, we determine the actual cost/savings of each plan change based on the individual benefits affected for the specific institution.

For example, the cost/savings for a change in copay for a physician office visit, emergency room, physical therapy, chiropractic or outpatient mental health is determined by multiplying the dollar change by the average of the total number of visits for that specific benefit for the past two policy years.

For a change in coinsurance, the cost/savings is determined by multiplying the percentage increase/decrease in coinsurance by the percentage that claims subject to that coinsurance level represents relative to the total costs of the program.

For institutions with plan premiums less than $2,500,000 or for new business, we use a larger institution as a proxy to develop our best estimate for the plan change, taking into account the differences in covered populations.

## Table F-1

### Actuarial Adjustment / New Business

| Criteria | Preferred Factor | Definition | | Undesirable Factor | Definition |
|---|---|---|---|---|---|
| | | | | | |
| Loss Ratio | Up to -2% | LT or equal to 80% | | Up to 2% | greater than 80% |
| Completeness of Information | Up to -2% | all required Data | | Up to 2% | incomplete Loss Data |
| Carrier Persistency | Up to -2% | 2 or less carriers past 5 years | | Up to 2% | More than 2 carriers |
| Enrollment/Participation Levels | Up to -2% | Consistent or increase | | Up to 2% | Below average |
| Network Utilization | Up to -2% | Greater than 80% | | Up to 2% | Less than 85% |
| Administrative Complexity | Up to -2% | Less than average | | Up to 2% | Greater than average |
| Change in Referral Patterns | Up to -2% | Adding a referral requirement | | Up to 2% | Decrease in referral requirement |
| Change in Staffing at SHC | Up to -2% | Increase in staffing or services | | Up to 2% | Decrease in staffing or services |

Note: maximum discount for all factors combined is 5%.

## Table F-2

### Actuarial Adjustment / New Business

### Student Health Insurance Plans that have significant changes in enrollment

| Enrollment | Factor |
|---|---|
| Mandatory with Waiver | 1.00 |
| Mandatory | .85 |
| | |
| **Student Status** | |
| Undergraduate | 1.00 |
| Graduate | 1.70 |
| Professional | 2.00 |
| | |
| **Student Status** | |
| Domestic | 1.00 |
| International | .80 |

## Table G

## Pediatric Dental Care**

| | In-Network Level | Out-of-Network Level |
|---|---|---|
| Annual Deductible (per person) | Not applicable | $50 |
| Coverage (Class) Type | % of fee paid | % of fee paid |
| Basic Coverage (Class A) | 100% | 90% |
| Intermediate Coverage (Class B) | 70% | 60% |
| Major Coverage (Class C) | 50% | 40% |
| Medically Necessary Orthodontia (Class D) | 50% | 50% |

## Pediatric Vision Care**

| | In-Network Level | Out-of-Network Level |
|---|---|---|
| Annual Deductible (per person) | Not applicable | Not applicable |
| Coverage Type | % of fee paid | % of fee paid |
| Diagnostic | 100% | fee schedule |
| Eyewear | | |
| Lenses | 100% | fee schedule |
| Frame Collection | 100% | fee schedule |
| Frame Non-Collection | $150 allowance | fee schedule |
| Contact Lenses | $150 allowance | fee schedule |

| | Dental | Vision |
|---|---|---|
| Projected Average Cost for Eligible Insured Students 2014-2015 Policy Year | $352 | $118 |
| Multiply by: | | |
| Proportion of Insured Members Under age 19 to the Insured Member Population | XX% | XX% |
| Divide by: | | |
| Medical Cost Ratio | 82% | 82% |
| Annual Premium per Insured Student: | | |

*For many institutions of higher learning, demographic information by age is available on the institution's website. Alternatively, 22-24% of undergraduates will be covered under the student health insurance plan with mandatory with waiver enrollment process. Freshmen (as a proxy to under age 19) typically represent 20% of the insured undergraduates.

**THP reserves the right to revise the above values as emerging experience dictates.

## Table H

### Second Year Premium Rate Cap

When an institution puts its student health plan out to bid for a given year, it generally requires that a cap on the rate increase for the subsequent plan year also be provided in the bid. The institution makes this requirement to preclude any bidding carrier from being overly aggressive in pricing the first year with the intent of rebalancing the premium rate with a large increase in the second year. From the carrier's perspective who is awarded the business for the first time, this requirement is not unreasonable because that carrier at the time to renew for the second year will only have about three months of claims experience from the first year, a baseline that is insufficient for experience rating.

The rate cap for the second year generally reflects the carrier's best estimate of trend for the renewal year. The underlying premise for a rate cap is that the carrier properly priced the plan in the first year and only a trend increase in needed in the second year. A margin of two to three points is generally added to the trend estimate to provide the carrier with some flexibility should the carrier's best estimate of trend change adversely in between the time the rate cap is quoted and the second year renewal is finalized, usually a period of about twelve months.

# Standard University

## 2014-15 Student Health Insurance Plan

## Retrospective Premium Agreement (Sample)

This Letter of Agreement (the "Agreement"), effective as of August XX, 2014, serves to document our mutual understanding and agreement of the circumstances under which Standard University would be entitled to return of potential premium surplus, based on claims experience, under Student Accident and Sickness Insurance Policy (Policy # XXXXXXXX) (the "Policy") between Standard University (the "Policyholder") and Tufts Health Plan (the "Company").

1. The retrospective premium agreement described in this Agreement will apply only to the 2014-2015 Policy Year. The agreement will apply to the Student Health Insurance Plan, the Dependent and Continuation coverage (if applicable) on a combined basis. The premium and claims associated with Accidental Death and Dismemberment, Worldwide Emergency Travel Assistance, and Medical Evacuation and Return of Mortal Remains will be excluded.
2. Retrospective Premium Calculation. For the aforementioned Policy Year and subject to the terms set below, the Company will perform a retrospective premium calculation twelve (12) months after the end of that Policy Year.
3. Incurred Claims. Incurred claims for that Policy Year will be defined as follows: total paid claims to date for that Policy Year completed to ultimate by means of an appropriate completion factor and then modified by the appropriate pooling adjustment. (Amounts in excess of the pooling point on individual claimants are removed and a pooling charge is applied. The pooling point and the corresponding pooling charge for that Policy Year will be the ones that otherwise would have applied to that Policy Year and used to prospectively rate the second subsequent renewal Policy Year).

4. Earned Premium. Earned premium for that Policy Year will be defined as follows: premium billed and due and remitted for the coverage provided with respect to that Policy Year.
5. Incurred Loss Ratio. An incurred loss ratio for that Policy Year will be defined as follows: incurred claims divided by earned premium (expressed to 3 decimal places).
6. Surplus. If the incurred loss ratio is less than .XXX (expressed to 3 decimal places), then a surplus is created; if the incurred loss ratio is equal to or greater than .XXX, there is no retrospective premium adjustment.
7. Refund. If a surplus is created, the refund is equal to: (A) X (B) X (C) where
   (A) is the absolute difference between the incurred loss ratio and .XXX
   (B) Is the earned premium for the 2014-2015 Policy Year
   (C) the University will receive XX% of the surplus below .XXX
8. Payment of Refund. The refund will be remitted to the Policyholder within 30 days of the date of the calculation provided the Policy remains in force through Policy Year 2014-2015. If the Policy terminates earlier, there will be no refund.
9. Use of Refund. Any and all refunds will be returned to the Policyholder. Upon request by the Policyholder, part or all of it will be applied against the payment of premiums as may be agreed to by the Policyholder and the Company. If the sum of student contributions which have been made for insurance exceeds the sum of premiums which have been paid for insurance (after giving effect to any refund), the excess will be applied by the Policyholder for the sole benefit of students. The Company will not have to see to the use of such excess.

If you are in agreement with the terms of this Agreement, please sign both copies and return one to me on or before August XX, 2014. Failure to return an executed copy of the Agreement prior to that date shall render this Agreement null and void.

THP

Signed: Tufts Health Plan Representative

Name: _____ ___/___/___

Date

Title: _____

Signed: Standard University Representative

Name: _____ ___/___/___

Date

Title: _____